LABORATORY REPORT

Redcliffe labs

Patient Name	: **Mrs Dummy**		
DOB/Age/Gender	: 45 Y/Female	Bill Date	: Feb 13, 2024, 11:09 AM
Patient ID / UHID	: XXX	Sample Collected	: Feb 13, 2024, 11:09 AM
Referred By	: Dr.Sushma Dikshit	Sample Received	: Feb 13, 2024, 12:20 PM
Sample Type	: Whole blood EDTA	Report Date	: Feb 13, 2024, 01:35 PM
Barcode No	: XXX	Report Status	: Final Report

MC-5280

Test Description	Value(s)	Unit(s)	Reference Range
HEMATOLOGY REPORT			
CBC + CA125			
Complete Blood Count (CBC)			
RBC Parameters			
Hemoglobin Method : Spectrophotometry	**10**	g/dL	12.0 - 15.0
RBC Count Method : Electrical impedance	4.1	10^6/µl	3.8 - 4.8
PCV Method : Calculated	**31.9**	%	36 - 46
MCV Method : Calculated	**78.5**	fl	83 - 101
MCH Method : Calculated	**24.8**	pg	27 - 32
MCHC Method : Calculated	31.5	g/dL	31.5 - 34.5
RDW (CV) Method : Calculated	**15.8**	%	11.6 - 14.0
RDW-SD Method : Calculated	35.5	fl	35.1 - 43.9
WBC Parameters			
TLC Method : Electrical impedance and microscopy	8.3	10^3/µl	4 - 10
Differential Leucocyte Count			
Neutrophils Method : Flow-cytometry DHSS	64	%	40-80
Lymphocytes Method : Flow-cytometry DHSS	29	%	20-40
Monocytes Method : Flow-cytometry DHSS	5	%	2-10
Eosinophils Method : Flow-cytometry DHSS	2	%	1-6
Basophils Method : Flow-cytometry DHSS	0	%	<2
Absolute Leukocyte Counts **Method : Calculated**			
Neutrophils.	5.31	10^3/µl	2 - 7
Lymphocytes. Method : Calculated	2.41	10^3/µl	1 - 3
Monocytes. Method : Calculated	0.42	10^3/µl	0.2 - 1.0

Dr. Islam Barkatullah Khan
MD (Pathology)
Consultant Pathologist

Booking Centre :- Dr. Ritu's Homeopathic Clinic & Collection Center, A-1103, Civitech Sampriti, Opp- Sita -2 Market, Sector 77, Noida Uttar Pradesh- 201309
Processing Lab :- Redcliffe Lifetech Pvt. Ltd., H-55, Sector-63, Noida, Uttar Pradesh - 201301

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Test Description	Value(s)	Unit(s)	Reference Range
Eosinophils. Method : Calculated	0.17	10^3/µl	0.02 - 0.5
Basophils. Method : Calculated	**0**	10^3/µl	0.02 - 0.5
Platelet Parameters			
Platelet Count Method : Electrical impedance and microscopy	324	10^3/µl	150 - 410
Mean Platelet Volume (MPV) Method : Calculated	**8.5**	fL	9.3 - 12.1
PCT Method : Calculated	0.3	%	0.17 - 0.32
PDW Method : Calculated	14.5	fL	8.3 - 25.0
P-LCR Method : Calculated	23.3	%	18 - 50
P-LCC Method : Calculated	76	%	44 - 140
Mentzer Index Method : Calculated	19.15	%	-

Interpretation:
CBC provides information about red cells, white cells and platelets. Results are useful in the diagnosis of anemia, infections, leukemias, clotting disorders and many other medical conditions.

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MC-5280

Test Description	Value(s)	Unit(s)	Reference Range

BIOCHEMISTRY REPORT

Glucose Fasting (BSF)

Glucose Fasting Method : Hexokinase	90	mg/dL	Normal <100 Prediabetes 100–125 Diabetes >=126

Interpretation:

Status	Fasting plasma glucose in mg/dL
Normal	<100
Impaired fasting glucose	100 - 125
Diabetes	=>126

Reference : American Diabetes Association

Comment :
Blood glucose determinations in commonly used as an aid in the diagnosis and treatment of diabetes. Elevated glucose levels (hyperglycemia) may also occur with pancreatic neoplasm, hyperthyroidism, and adrenal cortical hyper function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy insulinoma, or various liver diseases.

Note
1.The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL or a random / 2 hour plasma glucose value of > or = 200 mg/dL with symptoms of diabetes mellitus.
2.Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis.

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Test Description	Value(s)	Unit(s)	Reference Range

BIOCHEMISTRY REPORT

Fertility Panel - Female

TSH 3rd Generation

Thyroid Stimulating Hormone (Ultrasensitive) Method : CMIA	2.4033	µIU/mL	0.35 - 4.94

Interpretation:

Pregnancy	Reference ranges TSH
1 st Trimester	0.1 - 2.5
2 ed Trimester	0.2 - 3.0
3 rd Trimester	0.3 - 3.0

TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm . The variation is of the order of 50% . hence time of the day has influence on the measured serum TSH concentrations.

Primary malfunction of the thyroid gland may result in excessive (hyper) or below normal (hypo) release of T3 or T4. In addition as TSH directly affects thyroid function, malfunction of the pituitary or the hypo - thalamus influences the thyroid gland activity. Disease in any portion of the thyroid-pitutary-hypothala- mus system may influence the levels of T3 and T4 in the blood. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels may be low. In addition, in the Euthyroid Sick Syndrome, multiple alterations in serum thyroid function test findings have been recognized in patients with a wide variety of non-thyroidal illnesses (NTI) without evidence of preexisting thyroid or hypothalami c-pitutary diseases.

Thyroid Binding Globulin (TBG) concentrations remain relatively constant in healthy individuals. However, pregnancy, excess estrogen, androgen, antibiotics, steroids and glucocorticoids are known to alter TBG levels and may cause false thyroid values for Total T3 and T4 tests.

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Test Description	Value(s)	Unit(s)	Reference Range
BIOCHEMISTRY REPORT			
Fertility Panel - Female			
Luteinizing Hormone (LH)			
Luteinising Hormone-LH Method : CMIA	0.4	mIU/mL	Follicular Phase 1.80 - 11.78 Mid-Cycle Peak 7.59 - 89.08 Luteal Phase 0.56 - 14.00 Postmenopausal Females Without HRT 5.16 - 61.99

Interpretation:
Clinical Use
· Diagnosis of gonadal function disorders
· Diagnosis of pituitary disorders
Increased levels
· Primary hypogonadism
· Gonadotropin secreting pituitary tumors
Decreased levels
· Hypothalamic GnRH deficiency
· Pituitary LH deficiency
· Ectopic steroid hormone production
· GnRH analog treatment

Test Description	Value(s)	Unit(s)	Reference Range
BIOCHEMISTRY REPORT			
Fertility Panel - Female			
Follicle Simulating Hormone (FSH)			
Follicle Stimulating Hormone-FSH Method : CMIA	2.7	mIU/mL	Normally Menstruating Females Follicular Phase 3.03 - 8.08 Mid-Cycle Peak 2.55 - 16.69 Luteal Phase 1.38 - 5.47 Postmenopausal Females 26.72 - 133.41

Interpretation:
Clinical Use
· Diagnosis of gonadal function disorders
· Management and treatment of infertility in both genders
Increased levels
· Primary hypogonadism
· Gonadotropin secreting pituitary tumors
Decreased levels
· Hypothalamic GnRH deficiency
· Pituitary FSH deficiency
· Ectopic steroid hormone production

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Test Description	Value(s)	Unit(s)	Reference Range

BIOCHEMISTRY REPORT

Fertility Panel - Female

Prolactin (PRL)

Prolactin Method : CMIA	**89**	ng/mL	5.18 - 26.53

Please correlate clinically.

Interpretation:

Note:

1. Since prolactin is secreted in a pulsatile manner and is also influenced by a variety of physiologic stimuli, it is recommended to test 3 specimens at 20-30 minute intervals after pooling.
2. Major circulating form of Prolactin is a nonglycosylated monomer, but several forms of Prolactin linked with immunoglobulin occur which can give falsely high Prolactin results.
3. Macroprolactin assay is recommended if prolactin levels are elevated, but signs and symptoms of hyperprolactinemia are absent or pituitary imaging studies are normal

Clinical Use

· Diagnosis & management of pituitary adenomas
· Differential diagnosis of male & female hypogonadism

Increased Levels

· **Physiologic**: Sleep, stress, postprandially, pain, coitus
· **Systemic disorders**: Chest wall or thoracic spinal cord lesions, Primary / Secondary hypothyroidism, Adrenal insufficiency, Chronic renal failure, Cirrhosis
· **Medications**: **Psychiatric medications** like Phenothiazine, Haloperidol, Risperidone, Domperidone, Fluoexetine, Amitriptylene, MAO inhibitors etc.,

Antihypertensives: Alphamethyldopa, Reserpine, Verapamil

Opiates: Heroin, Methadone, Morphine, Apomorphine

Cimetidine / Ranitidine

· Prolactin secreting pituitary tumors: Prolactinoma, Acromegaly
· Miscellaneous: Epileptic seizures, Ectopic secretion of prolactin by non-pituitary tumors, pressure / transaction of pituitary stalk, macroprolactinemia
· Idiopathic

Decreased levels

· Pituitary deficiency: Pituitary necrosis / infarction
· Bromocriptine administration
· Pseudohypoparathyroidism

BIOCHEMISTRY REPORT

Fertility Panel - Female

Testosterone Total

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Test Description	Value(s)	Unit(s)	Reference Range
Testosterone Total Method : ECLIA	<2.50	ng/dL	Females(20-49 years of age) 8.4 - 48.1 Females (>=50 years of age) 2.9 - 40.8

Note:-Please correlate clinically.

Interpretation:

Reference values for Males (7-18 years) characterized by Tanner Stage

Tanner Stage	5-95th percentiles (ng/dL)
1	< 2.5
2	< 2.5 - 432
3	64.9 - 778
4	180 - 763
5	188 - 882

Reference values for females (8-18 years) characterized by Tanner Stage

Tanner Stage	5-95th percentiles (ng/dL)
1	<2.5 - 6.1
2	<2.5 - 10.4
3	<2.5 - 23.7
4	<2.5 - 26.8
5	4.6 - 38.3

Note

· All applications that require measurement of very low level of testosterone (eg hypogonadal men, children, virilization or intersex disorders in women etc) recommended test is Testosterone total, Ultrasensitive

· LC-MS/MS is the gold standard for steroid hormone assays due to increased sensitivity & specificity as compared to immunoassays

Clinical Use

· Assessment of testicular function in males

Increased levels

· Precocious puberty (Males)
· Androgen resistance
· Testotoxicosis
· Congenital Adrenal Hyperplasia

Decreased levels

· Delayed puberty (Males)

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Test Description	Value(s)	Unit(s)	Reference Range

· Gonadotropin deficiency
· Testicular defects
· Systemic diseases

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Test Description	Value(s)	Unit(s)	Reference Range

BIOCHEMISTRY REPORT

Fertility Panel - Female

Estradiol (E2)

ESTRADIOL(E2), SERUM Method : ECLIA	<5.00	pg/mL	

Result rechecked, Please correlate clinically .

Interpretation:

Population	Bio. Ref. Ranges in pg/mL
Normal Menstruating Females:	
Follicular Phase	21 - 251
Mid-Cycle Phase	38 - 649
Luteal Phase	21 - 312
Postmenopausal Females not on HRT	<10 - 28
Postmenopausal Females on HRT	<10 - 144
Males	11 - 44

HRT = Hormone Replacement Therapy

Note

1.All applications that require measurement of very low level of estradiol (eg men, children, post menopausal women, hypogonadal women etc) recommended test is Estradiol, Ultrasensitive

2. LC- MS/MS is the gold standard for steroid hormone assays due to increased sensitivity & specificity as compared to immunoassays

Clinical Use

1. Determine estrogen status in women

2. Monitor follicular development during induction of ovulation

3. Assess estrogen production in males

Increased Levels

1. Precocious puberty (female)
2. Male gynecomastia
3. Liver disease
4. Ovarian tumors
5. Adrenal feminizing tumors

Decreased Level

1. Oral contraceptives
2. Ovarian failure

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Test Description	Value(s)	Unit(s)	Reference Range

BIOCHEMISTRY REPORT

CBC + CA125

CA 125 (Ovarian Cancer Marker)

CA 125; OVARIAN CANCER MARKER, SERUM	25.3	U/mL	<35

Method : CMIA

Interpretation:

CA 125 is a surface antigen, identified as a 200 - 1000 kDa mucin-like glycoprotein associated with non-mucinous epithelial ovarian malignancy. CA 125 is a useful tumor marker for evaluating therapy and monitoring disease status
in patients under treatment for ovarian cancer. Measured serially the levels of CA 125 correspond with disease progression or regression. The rate of change in CA 125 is also highly prognostic. As a diagnostic tool however, the level of CA 125 alone is not sufficient to determine the presence of extent of disease. Levels of CA 125 should not be interpreted as absolute evidence of the presence or the absence of malignant disease. Before treatment, patients
with confirmed ovarian carcinorma frequently have levels of CA 125 within the range observed in healthy regarding the histological grade or diameter of the tumor mass.

Elevated levels of CA 125 can be observed in patients with nonmalignant diseases. Patients with certain benign conditions, such as hepatic cirrhosis, acute pancreatitis, endometriosis, pelvic inflammatory disease, menstruation and first trimester pregnancy show elevated levels of CA 125. Elevated levels are also found in 1 to 2 % of healthy donors.
Measurements of CA 125 sholud always be used in conjunction with other diagnostic procedures, including information from the patients clinical evaluation. The concentration of CA 125 in a given specimen determined with assays from different manufacturers can vary due to differences in assay methods, calibration, and reagent specificity. Values obtained with different assay methods cannot be used interchangeably. Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animal or to animal serum products can be prone to this interference and anomalous values may be observed

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Test Description	Value(s)	Unit(s)	Reference Range

BIOCHEMISTRY REPORT

Fertility Panel - Female

Anti Mullerian Hormone (AMH)

ANTI MULLERIAN HORMONE; AMH,SERUM	0.3	ng/mL	

Method : CLIA

Result rechecked, Please correlate clinically .

Interpretation:

Adult Reference Group	Age Range (years)	Reference Interval ng/mL
Females	18-25	0.96-13.34
Females	26-30	0.17-7.37
Females	31-35	0.07-7.35
Females	36-40	0.03-7.15
Females	41-45	0.00-3.27
Females	≥ 46	0.00-1.15
Males	> 18	0.73-16.05
Pediatric Reference Group		
Male Tanner Stage 1	8 - 13	4.95-144.48
Male Tanner Stage 2	8 - 17	5.02-140.06
Male Tanner Stage 3	10 - 19	2.61-75.90
Male Tanner Stage 4	12 - 18	0.43-20.14
Male Tanner Stage 5	11 - 19	1.95-21.20

Notes

1. AMH stars declining years prior to rise in FSH thus it is much more sensitive marker of ovarian reserve.
2. Discordant results between AMH and antral follicle count (AFC) may be observed as AMH reflects population of preantral follicles whereas AFC measures only those visualized-on USG

Comment

Antimullerian hormone (AMH), also known as mullerian-inhibiting substance is produced by Sertoli cells of the testis in males and by ovarian granulosa cells in females. In males, AMH serum concentrations are elevated under 2 years and then progressively decrease until puberty, when there is a sharp decline. In females, AMH is produced by the granulosa cells of small growing follicles from the 36th week of gestation onwards until menopause when levels become undetectable. Due to the gender differences in AMH concentrations, its changes in circulating concentrations with sexual development, and its specificity for Sertoli and granulosa cells, measurement of AMH has utility in the assessment of gender, gonadal function, fertility, and as a gonadal tumor marker. Since AMH is produced continuously in the granulosa cells of small follicles during the menstrual cycle, it is superior to the episodically released gonadotropins and ovarian steroids as a marker of ovarian reserve. Studies in fertility clinics have shown that females with higher concentrations of AMH have a better response to ovarian stimulation and tend to produce more retrievable oocytes than females with low or undetectable AMH. Females at risk of ovarian hyperstimulation syndrome after gonadotropin

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Test Description	Value(s)	Unit(s)	Reference Range

administration can have significantly elevated AMH concentrations. Polycystic ovarian syndrome can elevate serum AMH levels because it is associated with the presence of large numbers of small follicles. Serum AMH levels are increased in some patients with ovarian granulosa cell tumors, which comprise approximately 10% of ovarian tumors.

Clinical applications

· To assess ovarian status, including follicle development, ovarian reserve, and ovarian responsiveness, as part of evaluation for infertility and assisted reproduction protocols.
· To assess menopausal status, including premature ovarian failure.
· To assess ovarian function in patients with Polycystic ovarian syndrome (PCOS).
· To evaluate infants with ambiguous genitalia and other intersex conditions.
· To evaluate testicular function in infants and children
· To diagnose and monitor patients with AMH secreting Ovarian granulosa cell tumors.

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